RETINA AND UVEITIS CENTER

FINANCIAL POLICY

1. I hereby authorize Paragon Retina, PLLC to apply for benefits on my behalf and for payment of medical benefits directly to Paragon Retina, PLLC for services rendered. I request payments from Medicare, Medigap and/or any other insurance company to be made directly to Paragon Retina, PLLC. Authorization is hereby granted to release information contained in the patient's medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim.
2. As a courtesy, Retina and Uveitis Center verifies your benefits with your insurance company. Our verification of your insurance benefits is not a guarantee of payment. We highly recommend you also contact your insurance carrier and check your coverage for Ophthalmology Specialty Services. Do not assume that you will not owe anything if you have more than one insurance policy.
3. It is the policy of Retina and Uveitis Center that payment is due at the time of service. We require all patients to pay their deductible, copay, coinsurance, or self-pay amounts on the day of service and if I am unable to pay, my appointment will need to be rescheduled. In addition, all account balances will need to be settled before any future appointments are scheduled.
4. I understand that I am financially responsible for all charges for services rendered which may include services not covered by my insurance company. I agree that all amounts are due upon request and are payable to Paragon Retina, PLLC. I further understand that should my account balance become delinquent and sent to a third-party collector, I agree to pay an additional 30% of the balance or $50, whichever is greater. I also understand that a returned check fee of $35 will be assessed if the check is returned by my bank.

I have read, understand, and agree to the above Financial Policy and understand that by signing this agreement it is indefinite and continues until revoked in writing. I understand my financial responsibility to make payments for services provided to me and the courtesy of Paragon Retina, PLLC to submit claims on my behalf.

_____

Patient Name

_____ _____

Signature of Patient, Parent, or Legal Representative Date